

State of Idaho
DEPARTMENT OF INSURANCE

C.L. "BUTCH" OTTER
Governor

700 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043
Phone (208)334-4250
FAX # (208)334-4398

WILLIAM W. DEAL
Director

SUSPECT FRAUDULENT CLAIM REPORT

The reporting of suspected/fraudulent claims is a mandated requirement per Idaho Code 41-290.

DATE:

REFERRING PERSON:	INSURANCE COMPANY:
SIGNATURE:	ADDRESS:
TELEPHONE:	CITY/STATE/ZIP:

CLAIM #:	POLICY #:
WHERE CLAIM WAS FILED:	

TYPE OF CLAIM					
	AUTO		LIFE		RENTAL
	HOMEOWNER		HEALTH		BUSINESS
	W/C		AGENT		OTHER:

DATE OF LOSS:	LOCATION OF LOSS:			
CLAIM AMOUNT:	AMOUNT PAID:	DENIED?	Yes	No

REASON FOR REFERRAL:				
ORGANIZED/RING ACTIVITY?	Yes	No		

LAW ENFORCEMENT AGENCY:	REPORTING OFFICER:
DATE OF REPORT:	REPORT #:

INSURED/CLAIMANT INFORMATION

NAME OF CLAIMANT:	SS#:
ADDRESS:	DATE OF BIRTH:
TELEPHONE:	OCCUPATION:

NAME OF INSURED:	SS#:
ADDRESS:	DATE OF BIRTH:
TELEPHONE:	OCCUPATION:

OTHER INVOLVED PARTIES

NAME :			NAME:		
DOB:	SSN:		DOB:	SSN:	
ADDRESS:			ADDRESS:		
TELEPHONE:			TELEPHONE:		
Claimant	Informant	Witness	Claimant	Informant	Witness

LIST ANY AGENCY TO WHOM YOU HAVE REPORTED THIS (Use back of form if additional space is needed):
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FOR DOI USE ONLY		
INVESTIGATOR:	DOI:	DATE:

REFERRAL INFORMATION CONTINUED

REASON FOR REFERRAL:

ADDITIONAL INVOLVED PARTIES:

COMMENTS: